INSURANCE VERIFICATION FORM (as affects any health insurance reimbursement for Chiropractic services)

Patient's Name:_____

Date of Birth:_____ Today's Date:_____

Please have the following information when calling your insurance company:

1) Insurance company's phone number (on the back of your card):_____
2) Policy holder's name (if different from patient):_____

By calling your insurance you can verify the following information. It should give you the information on what reimbursement you may expect from them.

1) Ask for the name of the person giving you this information:_____

   1a. Date of this phone call to verify insurance benefits:_____

2) Ask if you have Chiropractic coverage for "out of network" providers. **If yes, please continue** to verify type and amount of coverage.

   A) What is the yearly deductible: Per Person:_____ Per Family:_____

   B) How much of the deductible has been met this year:_____

   C) What is the co-pay for Chiropractic visits:_____

   D) Is there a limit to the number of visits or $ amount?:_____ If yes, how many allowed_____ and/or what is the $ limit?:_____

   E) Are Chiropractic services limited to "Medical Necessity"?_____

   F) How do I send in a receipt for my Chiropractic services for insurance reimbursement?_____

   Requiring what forms or documents?_____

   G) What is the effective date of the policy:_____

   H) Policy holder's employer:_____ ID#_____

   Group# (if applicable to your policy):_____

   I) **Name and address of the insurance office where the claims are sent and where I send my paid receipts for Chiropractic services:**

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